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A Successful Case of Excision of the Rectum.

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TROY, N. Y.

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A SUCCESSFUL CASE OF EXCISION OF THE RECTUM.

By William Wotkyns Seymour, A. B., (Yale), M. D., (Harv.), Troy, N. Y.

Read by Title, November 18, 1884.

I first saw the patient, J. C., August 11, 1884. He is a farmer, aged sixty-six years, always of good habits, and never the subject of a severe illness save an attack of entero-colitis a year ago. His mother had a "cancerous" tumor removed from between the shoulder-blades forty years ago, and died, aged sixty-six, a year later, of its recurrence. A brother's daughter has a cancer of the breast. For a year and a half, the patient has experienced pain and difficulty on defecation, together with a grumous discharge from the bowel, which was attributed to hæmorrhoids; and for six months past the pain had been constant, and so excruciating that the patient besought me to kill him rather than to allow it to continue. Examination under ether revealed irregular nodular masses in the rectal walls, beginning about an inch above the anus and extending almost as high as the finger could reach on the anterior wall, when strong supra-pubic pressure was made. The caliber of the bowel was diminished, but the whole mass was movable, and the perinæum was lax. My diagnosis was cancer of the rectum, and the prognosis, of course, unfavorable. The patient was told that, for the relief of the increasing difficulty and pain on defecation, either curetting, linear rectotomy, or colotomy could be done, but that neither of these operations would remove the disease, although it might prolong life for a considerable time; but that, on the other hand, excision of the rectum, which was much more immediately dangerous, gave a faint chance of cure, or, if

immediately successful, quite as long relief as either of the other procedures.

The patient decided wisely, I think, for excision, which I proceeded to perform on the 6th of September, 1884. I was assisted by the family physician, Dr. C. A. Winship, of Eagle Mills, and by Dr. John Morris, of Troy, Mr. Hermon Gordinier, medical student, and Mr. David Winship. None of my assistants had ever seen the operation. The patient's bowels had been moved the morning of the operation by injection. Brandy was given by the mouth, ether was used as the anæsthetic, the patient was put in the exaggerated stone position, and the parts were scrubbed with carbolic soap and a nail-brush and then shaved. I then introduced a tampon into the bowel and made an elliptical incision half an inch from the anus, continuing it by incisions in the median line to the coccyx and just behind the scrotum. The posterior portions of the bowel were first freed, and then a sound was introduced into the bladder as a guide for the separation of the anterior wall from the prostate and bladder. All vessels were immediately seized with artery clamps, and the dissection was made with fingers and knife-handle, and, where the tissues were tough, by blunt scissors, between double ligatures. When the artery clamps became too many, the vessels were tied, at first with Kocher's catgut and afterward with silk boiled in a solution of bichloride of mercury. In this wise, little blood was lost, but considerable time was consumed. Much to my gratification, the bowel was easily separated from the bladder, and I finally was able to drag down the gut so as to get an inch of apparently sound tissue above the growth without opening the peritonæum. In this sound tissue, I made a transverse incision and removed the mass, the upper limits of which extended nearly five inches on the posterior wall and four inches on the anterior wall from the anus. During and after the operation, irrigations of the wound with a hot solution of salicylic acid were used. After searching for suspicious tissue in the opening and stopping all oozing, the anterior and posterior median portions of the wound were closed with silk sutures, and the end of the bowel was pulled down and stitched on with silk, a large, rubber drainage-tube being inserted at the posterior part of the wound. Iodoform was dusted over the wound, and a pad of absorbent cotton and T bandage were applied. Shock being marked, brandy was given subcutaneously and by the mouth.

The patient was put to bed with the trunk elevated, as recommended by Bardenheuer,[1] to favor drainage, and hot bottles were put around him. The operation lasted three hours. The temperature, save once, never rose above 101°, and the urine needed drawing only for three days. On the third day, the bowels were moved on account of flatulence. The patient had no pain and continued to improve from the first. The stitches and tube were removed on the eighth day, and good union was found of all save the posterior quarter of the bowel, where the strain had cut through the stitches. More than two months have elapsed since the operation. The patient has a normal appetite, absolutely no pain, can walk a mile or more, and has gained in flesh and feels much better than for two years preceding the operation.

The wound is now well healed, there is no evidence of recurrence, and the only inconvenience is the incontinence of fæces, which results in five or six movements a day, without warning. However, this incontinence seems to be improving as the wound contracts. Microscopic examination of the excised portion of the bowel showed the growth to be a cylindrical epithelioma. In the ulcerated portions of the growth, all traces of follicles were absent, and the morbid tissue showed an alveolar structure in which were large masses of cylindrical epithelial cells, many of which in their arrangement closely resembled adenoid tissue. In most places the reticulated tissue appeared to be made up of epithelium. In the less involved portion of the bowel, at each limit of the growth, there was infiltration of the follicular and submucous tissue with small, round cells, and in the submucous layer were occasional masses of cylindrical epithelium with gland-like arrangement. The upper limit of the excised portion was apparently healthy. I expect the propriety of the operation will be questioned, and that many will claim that as good if not better results could have been obtained by colotomy or linear rectotomy. Still, from the latter view I must dissent. Modern pathologists quite universally agree that cancer is primarily local; and the results obtained in radical antiseptic operations for removal of cancer of the mamma,

[1] "Zur Frage der Drainirung der Peritonealhöhle," Stuttgart, 1880.

uterus, and rectum would seem to bear out this proposition. So long as our means of controlling the accidents of excision (hæmorrhage and cellular inflammation) were defective, it is not surprising that colotomy and other temporizing methods were preferred. But now that the means of controlling hæmorrhage in long operations are so perfect, and the measures for controlling infection during and after the operation are so good, the question of the relative value of colotomy and excision of the rectum needs to be studied anew, notwithstanding the brilliant papers of Esmarch and Bryant at Copenhagen. Believing in the local origin of cancer and its slow infecting tendency in many cases, Bardenheuer[1] declares that there are no contra-indications to excision of the cancerous rectum, save immobility of the growth by reason of its size or attachments to the pelvis. Mere linear extent, necessitating the opening of the peritoneum, is, according to Volkmann, Esmarch, and Bardenheuer, no contra-indication. Bardenheuer successfully removed the rectum where the upper limits of the excised portion measured nine and thirten inches from the anus. Volkmann's incision, used in my operation, seems to give plenty of room without removing the coccyx, as is advised by some. When contra-indicated by the immobility of the tumor, excision of the rectum must give place to some form of colotomy, and here again I think modern antiseptic methods will decide eventually for an abdominal rather than a loin incision, with probably the modification suggested by Madeling, of Rostock, of completely severing the bowel and closing the lower severed end with sutures. When we consider the horrible sufferings entailed by cancer of the rectum, and the early age at which many are attacked (a case in a lad of seventeen years came under my observation when house-surgeon in the Boston City Hospital), an operation which promises, in some cases, according to its advocates, immunities of from four to eleven years, at only the expense of more or less incontinence of fæces, deserves a wider acceptance at the hands of the English-speaking world than it has heretofore received. In fact, the cases mentioned by Volkmann and Es-

[1] "Drain. der Peritonealhöhle," Stuttgart, 1880, p. 11.

march of non-recurrence and comfort for four, six, eight, and eleven years should be regarded as cures, and are encouraging to all who seek to mitigate the horrible sufferings of the cancerous subject. We do not give up hope in cancer of the breast; why should we in cancer of the rectum? As to the incontinence, it is common both to colotomy and excision, with the advantage of ease in maintaining cleanliness and the natural site of the artificial anus in favor of excision.